Supreme Court, U.S.
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No. 69-927

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

VISITING NURSE ASSOCIATION OF NORTH SHORE, ET AL.,
Petitioner,

v.

BRUCE M. BULLEN, ET AL.,
Respondent.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNTIED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

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36 pp

Questions Presented.

The Respondents disagree with the Petitioners' statement of the questions, and submit that this case raises the following issues:

1. Should the federal courts decline to defer to the administering federal agency's interpretation of its own regulations, simply because petitioners chose to sue the State under 42 U.S.C. § 1983 instead of challenging the federal agency's determination directly?

2. Do a State Plan and associated notices violate the Medicaid Act for want of detail not required by the statute or by the Secretary of the United States Department of Health and Human Services ("Secretary")?

3. After waiting nine months beyond the effective date of the class rates, may the petitioners now seek invalidation of those rates on the ground that the State should have convened a Medical Case Advisory Committee sooner, where petitioners themselves had extensive prior input into those rates?

4. Do 42 U.S.C. § 1396a(a)(30)(A) and its implementing regulations provide home health providers with procedural rights enforceable through 42 U.S.C. § 1983?

5. Did the Eleventh Amendment bar the Federal Courts from entering a judgment declaring that the past implementation of class rates of Medicaid reimbursement by the Commonwealth of Massachusetts was unlawful where the Commonwealth's revised plan amendment cured any violations of law and was approved by the Secretary prior to entry of the judgment?

Table of Contents.

Table of Authorities iii

Statement of Jurisdiction 1

Statement 2

A. *Statement of Proceedings* 2

B. *Adoption of the Regulations* 5

C. *The Three Sets of Rates* 5

D. *Subsequent Regulatory Activity* 6

Argument 7

I. THIS CASE IS NOT AN APPROPRIATE VEHICLE FOR MAKING PRONOUNCEMENTS ABOUT THE SCOPE OF DEFERENCE DUE TO FEDERAL AGENCIES. 7

II. THE CLASS RATES COMPLIED WITH THE PROCEDURAL REQUIREMENTS OF THE MEDICAID ACT. 12

A. *There is No Conflict in the Circuits or Within HCFA, Because The Medicaid Act Affords States Particular Procedural Flexibility in Setting Payment Mechanisms for Ambulatory Providers.* 12

B. *Petitioners Failed to Raise Their Medical Advisory Committee Issue in a Timely Fashion, and In Any Event, It is Wrong.* 14

III. THE INTERIM AND PHASE-IN RATES RAISE NO ISSUE WORTHY OF CERTIORARI. 17

IV. IN ANY EVENT, THE JUDGMENT BELOW WAS CORRECT, BECAUSE THE PETITIONERS HAD NO RIGHT OF ACTION UNDER THE PROCEDURAL REGULATIONS AT ISSUE. 19

Conclusion 25

Table of Authorities.

Cases.

BFP v. Resolution Trust Corp.,
511 U.S. 531 (1994) 13

Burgess v. Affleck, 683 F.2d 596
(1st Cir. 1982) 16

*Chevron v. Natural Resources Defense
Council*, 467 U.S. 837 (1984) 7, 8, 9

Chicago v. Environmental Defense Fund,
511 U.S. 328 (1994) 13

*Commonwealth of Massachusetts v.
O'Leary*, 925 F. Supp. 857
(D. Mass. 1996) 8

*Commonwealth of Massachusetts v.
U.S. Department of Transportation*,
93 F.3d 890 (D.C. Cir. 1996) 8

Commonwealth of Massachusetts v. U.S. Nuclear Regulatory Commission, 924 F.2d 311 (D.C. Cir.), *cert. denied*, 502 U.S. 899 (1991) 8

Commonwealth of Massachusetts on behalf of its Department of Public Welfare v. U.S. Department of Agriculture, 984 F.2d 514 (1st Cir.), *cert. denied*, 510 U.S. 822 (1993) 8

Commonwealth of Massachusetts on behalf of its Department of Public Welfare v. Yeuter, 947 F.2d 537 (1st Cir. 1991) 8

County of Los Angeles v. Lyons, 461 U.S. 95 (1983) 18

Edelman v. Jordan, 415 U.S. 651 (1974) 11, 19

Green v. Mansour, 474 U.S. 64 (1985) 11, 19

Indiana Ass'n of Homes for Aging, Inc. v. Indiana Office of Medicaid Policy & Planning, 60 F.3d 262 (7th Cir. 1995) 12, 17, 18

Massachusetts Hospital Ass'n v. Harris,
500 F. Supp. 1270 (D. Mass. 1980) 19

Massachusetts Mutual Ins. Co. v. Ludwig,
426 U.S. 479 (1976) 19

Oklahoma Nursing Home Ass'n v. Demps,
816 F. Supp. 688 (W.D. Okla. 1992),
appeal dismissed without op.,
9 F.3d 117 (10th Cir. 1993) 12

Oregon Ass'n of Homes for the Aging, Inc. v.
State Department of Human Resources,
5 F.3d 1239 (9th Cir. 1993) 12

Papasan v. Allain, 478 U.S. 265 (1986) 11

Pennhurst State School & Hospital v.
Halderman, 465 U.S. 89 (1984) 11

State v. Shalala, 42 F.3d 595
(10th Cir. 1994) 12

Stinson v. United States,
508 U.S. 36 (1993) 10

Thomas Jefferson Univ. v. Shalala,
512 U.S. 504 (1994) 10

United States v. New York Telephone Co.,
434 U.S. 159 (1977) 19

United States v. Slade, 980 F.2d 27
(1st Cir. 1992) 15

Visiting Nurse Association of the North Shore, Inc. v. Bullen,
866 F. Supp. 1444 (D. Mass. 1994) 3

Wilder v. Virginia Hospital Association,
496 U.S. 498 (1990) 19, 22

Statutes, Regulations & Court Rules.

28 U.S.C. § 1331 1

28 U.S.C. § 1346 1

42 U.S.C. § 1396a(a), Clause 13 12, 13, 14, 20, 23, 24

42 U.S.C. § 1396a(a), Clause 13(A) 19, 20

42 U.S.C. § 1396a(a), Clause 30	12, 13, 14, 20, 21, 22, 23, 24
42 U.S.C. § 1396a(a)(30)	23
42 U.S.C. § 1396a(a)(30)(A)	3, 9, 23
42 U.S.C. § 1396c	9
42 U.S.C. § 1396r-7	23
42 U.S.C. § 1396r-7(a)(3)	23
42 U.S.C. § 1983	1, 8, 9
Pub. L. 90-248, § 237	21
Pub. L. 97-35, § 2173	22
Pub. L. 97-35, § 2174	21, 22
Pub. L. 101-239, § 6402	23
Mass. Gen. Laws, c. 6A, § 32	18
Mass. Gen. Laws, c. 30A, § 2	18

42 C.F.R. § 430.12(c)	17
42 C.F.R. § 430.16(a)(ii)	10
42 C.F.R. § 430.20(b)	10
42 C.F.R. § 431.10	17
42 C.F.R. § 447.201(b)	17
42 C.F.R. § 447.204	22
42 C.F.R. § 447.256	10
42 C.F.R. § 447.271	23
42 C.F.R. § 447.371	23
114.3 C.M.R. 3.04(4)	18
114.3 C.M.R. 3.04(4)(b)	6
Fed. R. Civ. P. 25(d)	2

Miscellaneous.

H. Rep. No. 101-247 (1989) 22

Sen. Rep. No. 97-139 (1981) 22

1989 U.S. Constitution, Amend. XI 1, 4, 11, 15, 18, 19

U.S.C.C.A.N. 2116 (101st Cong. 1st Sess.) 22

NO. 96-927

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

Visiting Nurse Association of North Shore, et al.,
Plaintiffs-Appellees,
v.

Bruce M. Bullen, et al.,
Defendants-Appellants.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

Statement of Jurisdiction.

The District Court had jurisdiction under 28 U.S.C. §§ 1331 and 1346, except as withdrawn by the Eleventh Amendment to the United States Constitution, because the complaint challenges the legality of certain Massachusetts regulations under the federal Medicaid Statute and regulations, as well as under 42 U.S.C. § 1983. The respondents otherwise agree with petitioners' statement of jurisdiction.

Statement.

A. Statement of Proceedings

Nine home health providers brought this case against the Massachusetts Commissioner of the Division of Medical Assistance and the three Commissioners of the Rate Setting Commission (A-2).[1] The complaint challenges, among other things, the procedures used in adopting new rates to be paid to home health providers for services rendered to beneficiaries of the Massachusetts Medicaid program in and after fiscal year 1992 (A-4 to 5). As they changed, the regulations evolved from individual provider rates to class rates—that is, fixed rates for each type of service with limited adjustments to ensure access and quality, and to pay for interpreters or security (A-4). The Commonwealth filed a State Plan amendment (designated as "Amendment 003"), regarding the class rates in March, 1994.[2]

On August 18, 1994, the District Court granted partial summary judgment to the petitioners, holding invalid the class

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[1] The Commission Chair at the time the action was filed, Paula Griswold, has been succeeded by Barbara Weinstein. See Fed. R. Civ. P. 25(d). In addition, the defendants suggest that the case is moot as to South Shore VNA, since it is no longer paid under the challenged regulations.

[2] The full text of the plan amendment submitted at that time was:

> f. Home health care services—fixed fee schedules established by the Rate Setting Commission.

rates, effective January 1, 1994, on the ground that the Commonwealth had not provided an adequate notice and state plan amendment as required under the Medicaid Act. *Visiting Nurse Association of the North Shore, Inc. v. Bullen*, 866 F. Supp. 1444, 1457 (D. Mass. 1994)("*VNA*")(A-30 to A-61). On April 26, 1995, the Health Care Financing Administration (HCFA) approved the Commonwealth's plan (as amplified by the defendants' responses to HCFA's questions) effective January 1, 1994 (A-6).

The District Court entered its final judgment on May 26, 1995 (A-62). As amended on June 30, 1995, the Court's ruling reiterated that the class rates were invalid and directed entry of a declaratory judgment to that effect as of September 30, 1994 (A-62 to 63). It held that the defendants violated the August 24 order by implementing the class rates on October 1, 1994, *id.*, ¶ 5, but that the defendants were no longer in violation of the Court's Order as of November 1, 1994. *Id.*, ¶ 6. The Court held that the interim and phase-in rates did not violate the procedural requirements of the Medicaid Act with respect to notice and state plan content. *Id.*, ¶ 7. Finally, it noted that the Court "need not address claims concerning the substantive validity of the class rates implemented by defendants on January 1, 1994, since the Court has found that such rates were invalid" for procedural reasons. *Id.*, ¶¶ 8, 9. Both parties appealed.

On August 22, 1996, the United States Court of Appeals for the First Circuit vacated the District Court's Judgment and remanded the case for further proceedings on the petitioners' substantive claims (A-1 to 27). On the respondents' appeal, the Court held that the petitioners had a private cause of action under 42 U.S.C. § 1396a(a)(30)(A), but that HCFA had

lawfully approved the Commonwealth's state plan amendment and public notices implementing the class rate system effective January 1, 1994. The plan amendment, in particular, conformed to the level of detail that HCFA had approved for many years, and Massachusetts understood and reasonably relied upon that practice (A-19, 21) In granting deference to HCFA's determination, the Court noted that petitioners' failure to join HCFA as a party to this action compelled the Court to infer the rationale for the agency's longstanding practices at issue here (A-20).

The Court also rejected the petitioners' argument that the Commonwealth could implement the class rates only after convening a Medical Care Advisory Committee. Here, as elsewhere, HCFA reasonably determined that its approval of the plan amendment conformed to the requirements of the Medicaid Act (A-24 to 25 n.14). Since the Court held that Massachusetts did not violate the procedural provisions of the Medicaid Act, it did not reach the Commonwealth's arguments that (1) the District Court erred in ruling before HCFA acted on the plan amendment and (2) the District Court's declaratory judgment constituted retroactive relief barred by the Eleventh Amendment to the United States Constitution (A-24).

The Court's analysis of these issues also required rejection of the petitioners' appeal, which challenged the adequacy of the current state plan and the implementation of the interim and phase-in rates without a state plan amendment (A-26 to 27). Since the current state plan is more detailed than the version filed in March 1994, lawful approval of the latter necessarily implied the legality of the former. The Court held that the interim and phase-in rates did not require a plan amendment,

since they retained aspects of the pre-1991 cost-based rate system, which was already described adequately in the pre-1994 state plan (A-27).

B. Adoption of the Regulations

The Massachusetts Rate Setting Commission ("Commission") promulgates regulations governing rates of reimbursement through a notice and hearing process. In this case, the Commission also held a number of meetings, exchanges of information and consultations with affected industry members, including petitioners, and others, beginning in June 1991 (A-4).

The final regulations setting forth both the phase-in system and the class rates were published in the Massachusetts Register on or about May 21, 1993, well before they took effect on July 1, 1993, and January 1, 1994, respectively (A-54). Where the previous, approved Medicaid state plan provided for payment pursuant to a "fixed negotiated fee schedule," the plan as amended by Amendment 003 specified the method of payment as a "fixed fee schedule" to reflect the fact that the class rates are no longer determined separately for each provider (*id.*, A-176). Amendments to state plans take effect under federal law as of the first day of the calendar quarter in which an approvable plan amendment is submitted, here January 1, 1994. A-5 n.4.

C. The Three Sets of Rates

Prior to July 1, 1991, home health rates in Massachusetts were determined separately for each provider agency based upon that agency's audited costs, subject to certain caps and incentives (A-3). Effective July 1, 1991, the Commission tightened the caps on allowable costs, but instituted a relief

provision to ensure access and quality of care (A-53). This system, known as the Interim Rate System, was effective until June 30, 1993, when it was replaced by the so-called Phase-In rates that were effective through the end of calendar 1993 (A-53-54). The phase-in system continued to be based on each provider's reported costs, subject to an incentive and a cap (*id.*).

The class rates in effect since January 1, 1994 established the following fixed schedule for the six categories of services provided by home health providers:

Nursing Service	$55.76 per visit
Nursing Office Visit	$18.59 per visit
Physical Therapy	$55.85 per visit
Speech Therapy	$59.60 per visit
Occupational Therapy	$58.22 per visit
Home Health Aide Services	$18.70 per hour

114.3 C.M.R. 3.04(4)(b)(reprinted at 1st Cir. App. 173). The regulation allowed for adjustments for security and interpreter services. Several plaintiffs have received such adjustments (1st Cir. App. at 174, 587). It also allowed an adjustment to ensure access and quality (*id.*), which none of the plaintiffs has requested (1st Cir. App. at 568).

D. Subsequent Regulatory Activity

During September, 1994, after the District Court's summary judgment ruling, the defendants published a new, detailed notice in the Massachusetts Register (A-6). On December 30, 1994, the defendants submitted a new state plan amendment to HCFA,[3]

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[3] HCFA administers the Medicaid Act pursuant to a delegation by the Secretary of Health and Human Services (A-2 n.1).

designated as Amendment 023 (*id.*). As described in the notice and in the plan amendment, the effective date of the amendment was November 1, 1994 (*id.*).

On March 28, 1995, HCFA sent a letter to the respondents requesting clarification of the need for Amendment 023 in light of Amendment 003 (1st Cir. App. at 729, ¶ 8, 759). The respondents responded to that letter on April 21, 1995, and submitted a reply to HCFA's earlier request for additional information about Amendment 003 (1st Cir. App. at 728-729, ¶¶ 5, 6, 9; 732-745). On April 27, 1995, HCFA approved Amendment 003, after adding new pages from the defendants' response, effective 1/1/94 (A-6). Those new pages included the essence of Amendment 023. HCFA's plan language, as approved reads: "fixed fee schedule (see pages A1 - A9)" (1st Cir. App. at. 748-758). The referenced pages are the language from Amendment 023 (1st Cir. App. at 750-758).

Argument.

I. This Case Is Not an Appropriate Vehicle for Making Pronouncements About the Scope of Deference Due to Federal Agencies.

The petitioners' principal argument in favor of granting certiorari is that this Court should limit the application of *Chevron v. Natural Resources Defense Council*, 467 U.S. 837 (1984) (describing deference due to federal agencies' interpretation of federal statutes they administer). While the Commonwealth

probably loses more cases than it wins under *Chevron*[4]--and therefore is tempted to agree with some of petitioner's broad philosophical points--this case is factually and procedurally inappropriate for such a ruling for several reasons

In this first place, this case is not an Administrative Procedures Act ("APA") challenge to HCFA's decision. Rather than follow the normal, APA route, the petitioners assume that they may use this case, brought solely against state officials pursuant to 42 U.S.C. § 1983, to mount a collateral attack upon a federal agency decision that they never appealed. If the plaintiffs had brought an APA lawsuit, they could have challenged the sufficiency of the agency's decision or the adequacy of its statement of reasons. Instead, portions of their petition read like an APA complaint about the absence of findings (Pet. at 12) or of reasoned analysis in HCFA's decision (Pet. at 14). Having strenuously opposed the defendants' argument that the District Court should stay its hand pending a decision by the Secretary, and having urged the District Court to disregard the Secretary's final action, the plaintiffs now ask this Court to speculate about what errors HCFA might have committed.

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[4]See, e.g., *Commonwealth of Massachusetts on behalf of its Department of Public Welfare v. U.S. Department of Agriculture*, 984 F.2d 514 (1st Cir.), *cert. denied*, 510 U.S. 822 (1993); *Commonwealth of Massachusetts on behalf of its Department of Public Welfare v. Yeutter*, 947 F.2d 537 (1st Cir. 1991); *Commonwealth of Massachusetts v. U.S. Nuclear Regulatory Commission*, 924 F.2d 311, 324 (D.C. Cir.), *cert. denied*, 502 U.S. 899 (1991); *Commonwealth of Massachusetts v. O'Leary*, 925 F. Supp. 857 (D. Mass. 1996). But see *Commonwealth of Massachusetts v. U.S. Department of Transportation*, 93 F.3d 890 (D.C. Cir. 1996).

Had the plaintiffs challenged HCFA's action directly under the APA, the District Court could have determined the sufficiency of the agency's decision and, if necessary, remanded for additional findings or explanation. Even by plaintiffs' measure, an agency decision complying with any such order of remand would have merited *Chevron* deference. The claims that plaintiffs now seek to litigate in this Court would therefore never have existed. The ability of a plaintiff to bring an action under 42 U.S.C. § 1983 against a state agency, without joining the federal agency administering the statute--or even waiting for the federal administrative decision--is a powerful argument against attributing to Congress any intent to create private causes of action under 42 U.S.C. § 1396a(a)(30)(A). See below, pp. 19-24.

While the Court of Appeals entertained this civil rights action, it rightly refused to condone the petitioners' attempt to create an avenue that would circumvent federal agency authority. A-20 (". . . because plaintiffs have not chosen to join HCFA as a party defendant, see 42 U.S.C. § 1396c, we can only infer the rationale for HCFA's longstanding practice from its prior approval of Amendment 003 and its predecessor."). Far from the judicial abdication charged by the plaintiffs (Pet. at 10, 15), the Court of Appeals' decision safeguarded the separation of powers by refusing to entertain a flank attack upon the decision of an unrepresented agency whom Congress charged with administering the federal statute in question.

In such circumstances, the validity of the agency decision is final and unassailable. HCFA has authoritatively ruled that the Commonwealth's class rates may be applied as of January 1, 1994.

Second, the Plaintiffs are incorrect to challenge the application of *Chevron* deference. As the Court of Appeals noted (A-20), this

case involves the heightened deference due to an agency's interpretation of its own regulations under *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504 (1994); *Stinson v. United States*, 508 U.S. 36, 44 (1993). The issue pressed most vigorously by the petitioners is whether the effective date of the class rates should have been November 1, 1994 (the proposed effective date of Amendment 023) or January 1, 1994 (the effective date of the Commonwealth's original filing). The statute does not answer that question, leaving the matter to HCFA's regulations. In 42 C.F.R. § 430.20(b), HCFA has decreed that an "approvable plan" amendment is effective on the "first day of the quarter" in which the amendment is submitted. See also 42 C.F.R. § 447.256. The phrase "approvable plan" cannot be limited to plans containing all necessary information, because HCFA also has a regulation permitting it to request and receive additional information explaining or supporting the proposed plan amendment. 42 C.F.R. § 430.16(a)(ii). Harmonizing these two regulations was peculiarly within HCFA's expertise under the heightened deference articulated in *Stinson*. As discussed below (see pp. 12-14), HCFA's determination also receives support in the statutory structure, which contemplates substantially less detail in state plans for ambulatory providers than it does for institutions, such as hospitals and nursing homes.

Third, on the peculiar facts of this case, the application of the *Stinson* deference standard was particularly appropriate. The issue is not whether a new agency interpretation should receive deference. Rather, in this case, the Commonwealth was "entitled to place reasonable reliance" upon HCFA's longstanding construction of the statute as permitting a certain level of detail in state plans (A-21). When the Commonwealth replaced the

HCFA-approved "fixed negotiated fee schedule" language with the phrase "fixed fee schedule," the Commonwealth had no reason to expect large financial exposure for retroactive payments on the ground that the controlling statute required greater specificity than HCFA had required for well over a decade.

Fourth, the rates are indisputably valid today, after HCFA's approval of the extensive state plan amendment filed in the fall of 1994, which the plaintiffs do not challenge in this Court. In this posture, the only result of a ruling that the rates were invalid from July 1, 1991 to November 1, 1994 would be to permit the plaintiffs to seek damages in State Court. But such a ruling would violate the Eleventh Amendment to the United States Constitution. *See Green v. Mansour*, 474 U.S. 64, 68 (1985) (affirming dismissal where claims for prospective relief was moot and Eleventh Amendment barred retrospective relief). The Eleventh Amendment bars any claims for retroactive relief against the defendant officials, because such claims would have an impact directly on the Commonwealth. *See Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 102-03 (1984); *Edelman v. Jordan*, 415 U.S. 651, 677 (1974). *See Papasan v. Allain*, 478 U.S. 265, 278 (1986); *Green v. Mansour*, 474 U.S. 64, 68 (1985) ("We have refused to extend the reasoning of [*Ex Parte*] *Young*, however, to claims for retrospective relief. . . . [C]ompensatory or deterrence interests are insufficient to overcome the dictates of the Eleventh Amendment.") (citations omitted).

Finally, the Court of Appeals remanded the case to the District Court to hear the substantive Boren Amendment claims. While the respondents believe those claims to be without merit--and the petitioners have sent respondents a letter promising to dismiss the substantive claims if certiorari is denied--the plaintiffs have not

formally dismissed them. Accordingly, the case as it now stands is subject to further action in the lower courts, which ordinarily should occur before any consideration of certiorari.

II. THE CLASS RATES COMPLIED WITH THE PROCEDURAL REQUIREMENTS OF THE MEDICAID ACT.

A. *There is No Conflict Among the Circuits or Within HCFA, Because The Medicaid Act Affords States Particular Procedural Flexibility in Setting Payment Mechanisms For Ambulatory Providers.*

The petitioners are simply wrong in asserting a conflict between the opinion below and decisions of the Secretary and of other Circuits on the level of specificity required in a state plan. Indisputably, the visiting nurse organizations that brought this lawsuit are non-institutional providers, covered by 42 U.S.C. § 1396a(a), Clause 30 ("Clause 30"). The decisions that petitioners cite uniformly involve institutional providers, such as hospitals or nursing homes, which are subject to the additional requirements of 42 U.S.C. § 1396a(a), Clause 13 ("Clause 13"). *Indiana Ass'n of Homes for Aging, Inc. v. Indiana Office of Medicaid Policy & Planning*, 60 F.3d 262, 269 (7th Cir. 1995); *State v. Shalala*, 42 F.3d 595 (10th Cir. 1994); *Oregon Ass'n of Homes for the Aging, Inc. v. State Department of Human Resources*, 5 F.3d 1239 (9th Cir. 1993). *Oklahoma Nursing Home Ass'n v. Demps*, 816 F.Supp. 688 (W.D. Okla. 1992), *appeal dismissed without op.*, 9 F.3d 117 (10th Cir. 1993). This distinction is significant, and undoubtedly explains the fundamental similarity between this case and the ones petitioners cite--in each case, the courts have upheld the position taken by the Secretary.

As the Court of Appeals noted (A-18), the Medicaid Act "arguably" distinguishes between the level of specificity required in state plans for institutional providers and for non-institutional providers. Even in the absence of an APA challenge to HCFA's determination, there is good evidence that HFCA's ruling in this case follows this distinction. As the record in this case shows, HCFA has approved very concise statements in state plans for Clause 30 providers, including the language "fixed negotiated fee schedules" to describe the methods and procedures for paying home health providers in Massachusetts. Clause 30 does not require standards for determining "rates" (nor does it use the phrase "methods and standards"), but contains more general language regarding "such methods and procedures relating to . . . the payment for, care and services available under the plan . . . . as may be necessary to" meet the statutory objectives. By contrast, Clause 13 requires that the State provide for payment to hospitals and other institutions "through the use of *rates* (*determined in accordance with methods and standards* developed by the State which [meet certain conditions])" (emphasis added) about which the State must make certain "findings and assurances."

"'[It] is generally presumed that Congress acts intentionally and purposely when it includes particular language in one section of a statute but omits it in another.'" *BFP v. Resolution Trust Corp.*, 511 U.S. 531, 537 (1994), quoting *Chicago v. Environmental Defense Fund*, 511 U.S. 328, 338 (1994). A "method and procedure" "relating to" "payment" is significantly less elaborate than a "method and standard" for "determin[ing]" "rates." Not all methods and procedures need be described under Clause 30, but only such "as may be necessary." The absence of "findings and assurances" requirements in Clause 30 also has great significance,

since state plans (and notices thereof) under Clause 13 contain a level of detail necessitated by that clause's "findings and assurances" language—detail that the statute does not require for home health providers. Congress has thus decreed that state plan amendments (and the associated notices) under Clause 30 *need not* contain such detail that they effectively constitute "findings and assurances" or descriptions of "methods and standards" for "rates."

In short, the differences in language within the Medicaid Act reflect different, and more general requirements for non-institutional providers as compared to hospitals and nursing homes. The evidence strongly suggests that HCFA has been applying this distinction uniformly, and has been upheld by the Circuit Courts in doing so. The petition, which assumes the opposite, fails to demonstrate any conflict among the Circuits, particularly in the absence of any APA challenge, which could have shed light on HCFA's position for once and for all.

B. *Petitioners Failed to Raise Their Medical Advisory Committee Issue in a Timely Fashion, And In Any Event, It Is Wrong.*

The plaintiffs also attempt to invalidate the class rates based upon lack of consultation with the medical care advisory committee ("MCAC"). The petitioners raised no MCAC issue in their motion for summary judgment regarding the class rates, which was the subject of the District Court's August 18, 1994 opinion. They did not even make allegations about the MCAC until September 1, 1994 (A-25 n.14). They made only passing references to it in discussing the class rates thereafter. In short, the District Court did not simply fail to rule on the MCAC issue; the plaintiffs' mere

"passing allusions" waived that issue. *See United States v. Slade*, 980 F.2d 27, 30 (1st Cir. 1992) and cases cited.[5]

In any event, the respondents indisputably complied with any applicable MCAC requirements no later than October 4, 1994. See A-25 n.14. Entry of a judgment many months later adjudicating the MCAC issue would therefore have been moot, since there was no longer any live dispute on the issue. Even if otherwise proper, the Court could not have entered a nunc pro tunc judgment on the issue as of September 30, 1994, since the issue was not presented for District Court decision, let alone actually decided, as of that date. The Court likewise could not award retrospective relief on the issue, in light of the Eleventh Amendment.

Finally, the plaintiffs have not presented sufficient support for prevailing upon the MCAC issue on the merits. The First Circuit properly upheld HCFA's approval in this regard as well (A-24 to 25 n.14). Even apart from the inadequacy of the record,[6] which does not reflect notice and opportunity for the respondents to be heard on the point, the plaintiffs have not shown that any defect in MCAC procedures would entitle them to invalidation of the rates, as opposed to an order for simple compliance with MCAC

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[5] This MCAC contention is wrong for another reason as well, namely that the District Court's judgment did not generally enjoin the class rates, but specifically entered declarations on the notice and state plan issues. The plaintiffs therefore ask for relief that goes *beyond* what the District Court granted, contrary to their suggestion that the order should be "affirmed on other grounds."

[6] Because the plaintiffs never pressed the MCAC issue, the record does not reflect the full history of presentation of the MCAC, but does reflect notice of discussion before the MCAC at its October, 1994 meeting (First Circuit Appendix at 365, 379).

requirements. It is unassailable, for instance, that after consultation with the MCAC, the Commonwealth readopted and ratified the same rate schedule embodied in the original regulations. Any delay in MCAC consultation was harmless, particularly where the petitioners' own participation in the Commonwealth's administrative rate making process protected their interests as well as or better than any consultation with MCAC ever could. The petitioners also cannot gainsay that they themselves delayed in raising the MCAC issue until after the August 18, 1994. By their own account, they knew or should have known about the MCAC issue no later than November, 1993 (1st Cir. App. at 455-457), when it was still possible to comply with any MCAC requirement prior to the 1994 effective date of the class rates. Had the petitioners raised the issue sooner, the respondents could have taken earlier "curative" steps, thereby reducing their potential liability. *See Burgess v. Affleck*, 683 F.2d 596, 601 (1st Cir. 1982)("By waiting instead to enjoin [the new rates], plaintiffs have much increased the potential detriment to the state."). In these circumstances, a declaration of invalidity would have been inappropriate. If the petitioners had properly and timely presented this claim, they would at most have been able to obtain relief directed at compliance. Since the State already achieved compliance, however, the petitioners were entitled to nothing on this point as of May 18, 1995, when final judgment first entered.

III. THE INTERIM AND PHASE-IN RATES RAISE NO ISSUE WORTHY OF CERTIORARI.

The plaintiffs attack the transitional rates (i.e. the interim and phase-in rates) on the ground of alleged non-compliance with 42 C.F.R. § 447.201(b) and 42 C.F.R. § 430.12(c). Section 447.201(b) requires that the state plan "describe the policy and methods to be used in setting payment rates for each type of service included in the State's Medicaid program." Section 430.12(c) requires a plan amendment in the event of "[m]aterial changes in state law, organization, or policy, or in the state's operation of the Medicaid program . . . *[s]o that HCFA can determine* whether the plan continues to meet the requirement for approval." (emphasis added).

The key aspect of the regulatory scheme, as reflected in the italicized language, is that the state plan amendment must be sufficient for HCFA's purposes. This provision mirrors the requirement that the original state plan "contain[] all information necessary *for HCFA* to determine whether the plan can be approved . . .." 42 C.F.R. § 431.10 (emphasis added). HCFA's determination of what it itself needs in order to approve a plan arguably should be conclusive, and at least must be entitled to utmost deference. *See Indiana Association of Homes for the Aging v. Indiana Office of Medicaid Policy and Planning*, 60 F.3d 262, 269 (7th Cir. 1995). If a particular detail is not in a HCFA-approved plan, then "as a matter of law . . . the challenged formula is not a 'method or [procedure]' for setting payment rates that must be included in the plan." *Indiana Association*, 60 F.3d at 269.

In this case, HCFA and the Commonwealth flexibly defined the

approved "methods and procedures" from at least 1974 to 1994 as a "fixed negotiated fee schedule." (A-364 to 365, 368 to 378). No other details of the rate mechanism were "methods and procedures" within the meaning of the Medicaid Act. *Indiana Association*, 60 F.3d at 269. Plaintiffs did not challenge the pre-1994 HCFA approvals of these plans.

A comparison of the pre-1991 rates with the subsequent interim and phase-in rates demonstrates no change in "methods and procedures" embodied in the concept of a "fixed negotiated fee schedule." All of these rates were calculated for individual providers from "the base year's [reimbursable] costs adjusted for inflation, a productivity standard, a productivity incentive and an overhead adjustment." 114.3 C.M.R. 3.04(4). All of these rates constituted a "fixed negotiated fee schedule" in that they produced a schedule of "unique rates" for each service for each provider, based upon regulatory allowances and disallowances of certain costs on a provider-specific basis.[7]

In any event, since the transitional rate methodology was replaced by a different methodology even before plaintiffs filed this lawsuit, any prospective relief was moot. *See County of Los Angeles v. Lyons*, 461 U.S. 95 (1983). The Eleventh Amendment

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[7] The plaintiffs purport to gain support for their argument from the fact that the defendants published notices for adopting each of the transitional rates. These notices, however, were required by Mass. Gen. Laws, c. 6A, § 32 and c. 30A, § 2. The fact that defendants gave notice therefore does not amount to an admission that the federal law required a plan amendment. Any contrary conclusion would induce the States to refrain from publication except when federally required—precisely the opposite of the policy favoring provider participation that the plaintiffs purport to vindicate.

bars a declaration with regard to the validity of the transitional rate methodology while it was in effect. Such a retrospective declaration would be functionally equivalent to a money judgment against the Commonwealth, which the Eleventh Amendment prohibits. *Green v. Mansour*, 474 U.S. 64, 73 (1985); *Edelman v. Jordan*, 415 U.S. 651, 667-69 (1974). It is no answer that the judgment would be a declaration rather than a money judgment. "*Edelman* and its progeny clearly prevent the federal courts from achieving through the artful use of injunctive relief the identical result obtained by a retroactive award of money damages." *Massachusetts Hospital Ass'n v. Harris*, 500 F. Supp. 1270, 1279 (D. Mass. 1980).

IV. In Any Event, The Judgment Below Was Correct, Because the Petitioners Had No Right of Action Under the Procedural Regulations at Issue.

More broadly, the issue identified by the petitioners is not presented in this case because unlike Clause 13(A), Clause 30 of 42 U.S.C. § 1396a(a) does not create substantive provider-enforceable procedural rights upon which the petitioners premise their procedural claims.[8]

In *Wilder v. Virginia Hospital Association*, 496 U.S. 498

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[8]Because a ruling for the respondents on this point would not alter the judgment with respect to the adequacy of either the notice or the contents of the State Plan, the respondents are not required to present this point in a cross-appeal. *E.g., United States v. New York Telephone Co.*, 434 U.S. 159, 166 n.8 (1977); *Massachusetts Mutual Ins. Co. v. Ludwig*, 426 U.S. 479, 480-81 (1976).

(1990), the Court held that Clause 13(A) creates a right enforceable by hospitals and nursing homes to rates meeting substantive statutory criteria. Although the immediate purpose of the Boren Amendment was to give the States greater freedom from oversight by the Secretary, *see id.* at 506-08, nevertheless the Court determined that hospitals and nursing homes are the intended beneficiaries of the provision, since "[t]he provision establishes a system for reimbursement of providers and is phrased in terms benefiting health care providers: It requires a state plan to provide for 'payment . . . of the *hospital* services, *nursing* facility services, and services in an *intermediate care facility* for the mentally retarded provided under the plan.'" *Id.* at 510 (emphasis by the Court). The Court also found support for its view of the statute in the history of the Boren Amendment, which shows that "while Congress gave States leeway in adopting a method of computing rates . . . Congress retained the underlying requirement of 'reasonable and adequate' rates." *Id.* at 515.

The situation is wholly different with respect to Clause 30. Unlike Clause 13, Clause 30 does not require the State to pay for services through the use of rates; does not require the State to find, or make assurances satisfactory to the Secretary, that its rates meet any particular federal standard; and does not establish a federal standard of adequacy based on the costs either of a participating provider or of a hypothetical efficient and economically operated provider, nor specify that payments must be sufficient to reimburse providers their costs of complying with federal and state health and safety standards. Clause 13's measurement of rates paid to specific classes of providers against an objective standard indicated to the this Court that Congress intended some benefit or protection for those providers. Conversely, Clause 30's focus on expenditures for

services (rather than rates for specific providers), and its very general requirement that such expenditures be "consistent with" "efficiency, economy, and quality of care," and that they be "sufficient to enlist enough providers," demonstrates that Congress did not intend to benefit or protect noninstitutional providers by establishing a federal minimum standard to govern their reimbursement rates.

Clause 30's genesis, purpose, and development were completely separate from Clause 13. Clause 30 was enacted by the Social Security Amendments of 1967, Pub. L. 90-248, § 237, as part of a package of amendments designed to control utilization of nursing home care.[9] It remained unchanged in material part until 1981, the year following enactment of the Boren Amendment. Then, in the Omnibus Budget Reconciliation Act ("OBRA") of 1981, Pub. L. 97-35, § 2174, the Congress removed the reasonable charge limitation, so that the section required the State plan to:

> provide such methods and procedures relating to . . . the payment for[] care and services . . . to assure that payments are consistent with efficiency, economy, and quality of care.

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[9]As originally enacted, the provision quite clearly was not intended to benefit providers; the act required State plans to:

> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.

OBRA § 2174 immediately follows the section which brought hospital services under the reimbursement standard enacted the previous year by the Boren Amendment. While the legislative history of § 2173, which is extensively quoted in *Wilder* at 515 n.13, indicates residual concern that State reimbursement of hospitals must meet some federal standard of adequacy, quite the opposite is true of the history relating to § 2174 and noninstitutional reimbursement. Instead, the Senate Report indicates Congress's understanding that, at most, State reimbursement of noninstitutional providers was subject to a ceiling, which was to be determined in the aggregate rather than provider by provider. Sen. Rep. No. 97-139, at 473, 478 (1981). Thus, while OBRA § 2173 extended the relatively detailed substantive and procedural reimbursement standards of the Boren Amendment to hospitals, § 2174 left the States free of all federal standards with regard to noninstitutional reimbursement, save the aggregate limit on expenditures.

Congress added the "equal access" provision to Clause 30 in the Omnibus Budget Reconciliation Act of 1989. According to the history of that enactment, Congress was concerned that, as a result of low reimbursement levels and for other reasons, there were inadequate numbers of physicians, and particularly obstetricians and pediatricians, participating in the Medicaid program in some geographic areas. To address that concern, Congress codified the "equal access" provision already in the Secretary's regulation 42 C.F.R. § 447.204. H. Rep. No. 101-247 at 390 (1989), 1989 U.S.C.C.A.N. 2116 (101st Cong., 1st Sess.).

Although even this minimum federal test of adequacy could be said to offer some benefit to providers, it still cannot be construed

to confer an enforceable procedural right on providers as such, because the measure of adequacy under the provision is access to services, not whether particular rates reimburse provider costs. In this respect the Equal Access provision contrasts strikingly with other provisions of the same amendment. Although the Equal Access provision applies to all categories of covered care and services, Congress was sufficiently concerned about obstetrical and pediatric care to enact detailed requirements with respect to reimbursement for those categories of care. Pub. L. 101-239, § 6402, adding 42 U.S.C. § 1396r-7. Section 1396r-7 requires the State to specify the rates of payment for obstetrical and pediatric services in the State plan, and to submit information sufficient to enable the Secretary to determine whether the rates will ensure adequate access to such services. The Secretary is required to determine whether the State plan for such services complies with § 1396a(a)(30)(A) within 90 days of the State's submission. § 1396r-7(a)(3). These provisions, like Clause 13, explicitly require the State to fix rates of reimbursement for certain providers, and explicitly require review of the rates by the Secretary. Congress's choice not to impose similar requirements generally under Clause 30 clearly implies an intention not to create a privately enforceable general federal procedural requirement for reimbursement of noninstitutional providers.

This conclusion finds strong confirmation in applicable regulations. Under 42 C.F.R. §§ 447.271 through 447.371, the Secretary has specified various upper limits on reimbursements under State medical assistance plans. The source of the authority to impose those upper limit requirements is Clause 30, according to the Secretary. *See* 52 Fed. Reg. 28144 (July 28, 1987) (identifying 42 U.S.C. § 1396a(a)(30) as basis for upper limit requirement).

While federal regulations also provide substantive and procedural standards for inpatient hospital and long-term care facility services, in accordance with Clause 13, they provide no such standards with respect to other providers under Clause 30. Thus, the Secretary's regulations support the defendants' interpretation of Clause 30 as a limit on provider reimbursement but not a standard which might be considered a procedural right enforceable by providers.

Because Clause 30 does not create substantive provider enforceable procedural rights with respect to levels of reimbursement, the petitioners' claim of inadequate detail in the public notice and in the State Plan amendment fails in its premise.

Conclusion

For the foregoing reasons, the Court should deny the petition for certiorari.

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